Advanced Specialty Education
University of Maryland Dental School
Endodontics, Periodontics and Prosthodontics
650 W. Baltimore Street 4 South 4319
Baltimore, MD 21201
410-706-8111

Date ___________________________

Dear Doctor, Parent and Patient:

<u>Peridontal MA Referral Form – for children w/MA <21yo</u>

Please complete the following for both the patient and the parent/guardian, so we can submit treatment information to your insurance for pre-authorization. **Return this 1) completed form and 2) copy of the front & back of your child's insurance card to Ms. Angela Dudley** to the address above. **<u>Copies</u> of any pertinent x-rays may be given to the patient to bring to the initial appointment.** Your cooperation is needed to provide all requested information for the benefit of the patient, and is very much appreciated.

Patient name: ____ **Male** ____ **Female** ____

Address: ____ **City, State** __________________________

Zip ______________ **Daytime Ph#** ______________________ **Patient's Date of Birth** ________________

Patient's SS# ___________________________**Medical Assistance 11 digit #** __________________________

Medical Assistance MCO Insurance Plan Name ____

Parent/Guardian name ____________________________________ **Relation to Patient** ______________

Parent/Guardian DOB _______________________ **Parent/Guardian SS#** __________________________

Name of Referring Dentist: ____

Address of Referring Dentist: ____

City, State ____ **Zip** _________________________

Dentist Phone # _________________________________ **Diagnosis & Symptoms** ______________________

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Last Hygiene Maintenance__________________________ **Last Panoramic x-ray** _________________

Last BW x-rays ______________________________**Last Full Series of x-rays**____________________

BCDS Office Use Only:

Received _________________ **Assigned** _____________________ **PR#** _____________________

ad Perio Info MA Pre-auth 3-09 Rev 1-28-10